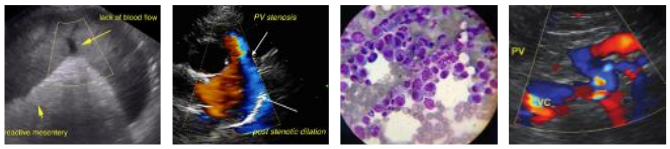
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Leo Risner

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

17 Years

WEIGHT

3.6 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shpores VEC

REFERRING VET

Dr. Lupole

INVOICE

21936

DATE

4/11/23

PRESENTING CLINICAL SIGNS

History: Presented at our hospital for hospitalization. Patient has been a picky eater since Solensia injection 3/20. The last week decreased appetite. Vomited Wednesday last week and yesterday after oral Cerenia. Owner went to RDVM today, bloodwork performed, suspect hepatic lipidosis, patient icteric, and doughy abdomen. Previous Health Concerns: hepatic lipidosis, chronic kidney disease, arthritis, hyperthyroid Current Medications: methimazole 2.5mg BID, Cerenia ¼ SID Sunday and Monday, Solensia injection 3/20 Appetite/When did they eat last: decreased appetite for a week

Abnormal PE/Chem/CBC/UA Results: rDVM K+3.2(L) Na 166 (H) ALT 959(H) ALP 202 (H) GGT 16 (H) bili 1.8(H) fPL here- normal: rad here- no obvious fb/ mass/ effusion All normal liver values 2/2023

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal in size (3.67 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal in size (3.59 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The adrenal glands are unable to be well visualized in these images.

Spleen

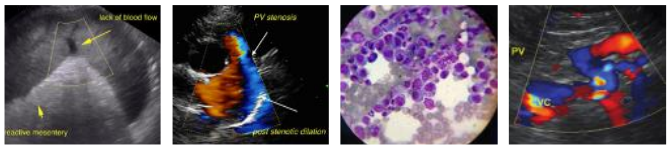
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. The cystic and common bile duct are tortuous in appearance but not pathologically distended, however, there is hyperechoic enhanced mesenteric fat surrounding the common bile duct.

Gastrointestinal



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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.

- A tortuous but not pathologically distended cystic and common bile duct are often a normal anatomic variant in a senior cat, however, given the mildly enhanced mesenteric fat surrounding the biliary system, an acute cholangitis or potentially acute on chronic cholangitis/cholangiohepatitis cannot be ruled out and should be suspected if supported by clinical and laboratory changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This patients history combined with the laboratory changes reported and the appearance of the liver are concerning for a hepatic lipidosis brought on by the reportedly decreased appetite. However, given the biliary changes, concurrent cholangitis/cholangiohepatitis can't be ruled out. Therefore, recommendations include fluid therapy, anti-emetics, gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad-spectrum antibiotics. Nutritional support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.

Pending patient response, etc., if inappetence persists, other diagnostic considerations could include a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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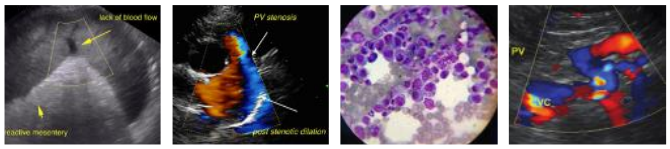

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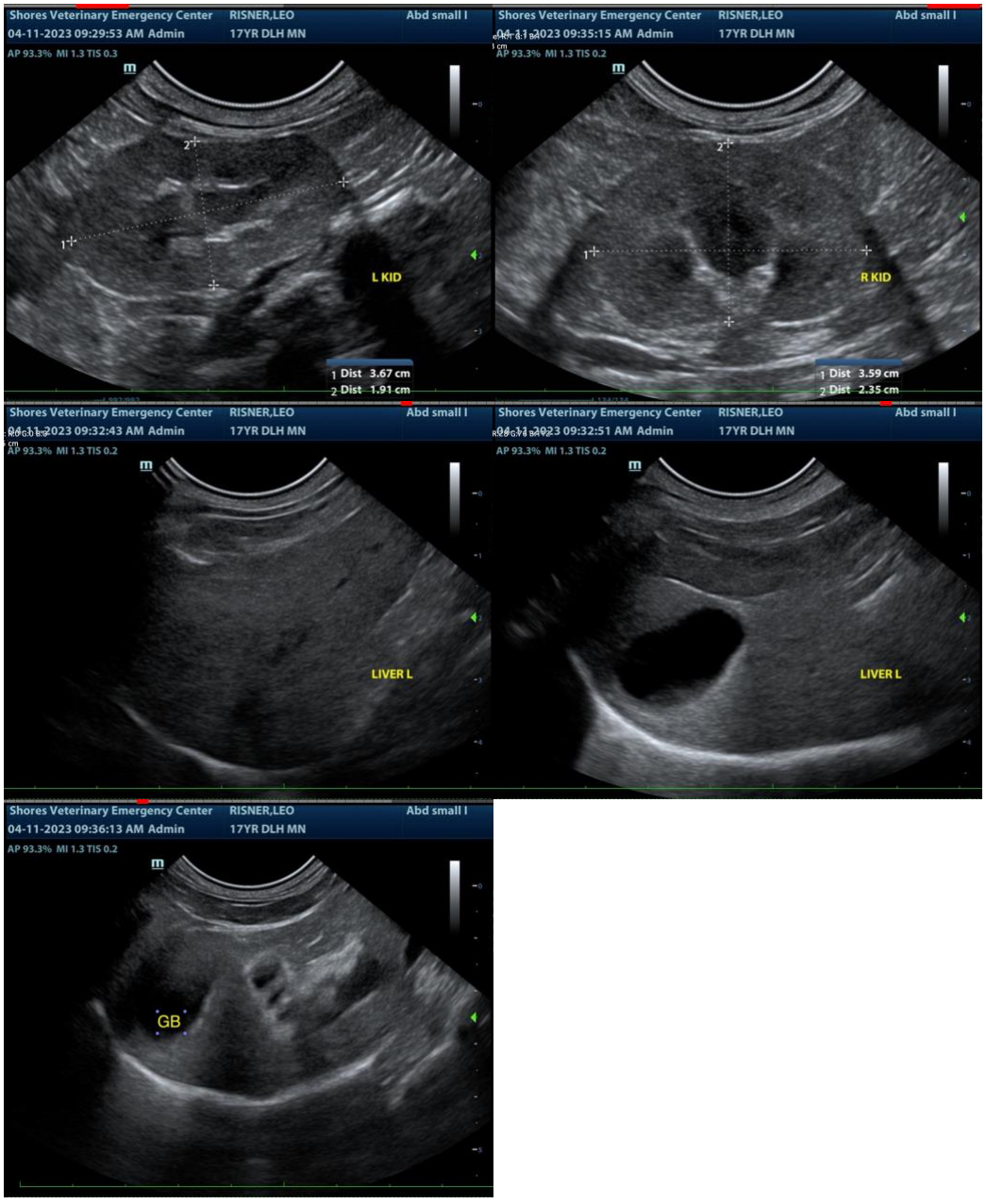

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com

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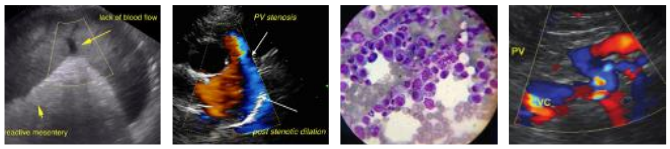

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